

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555808	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/16/2025
NAME OF PROVIDER OR SUPPLIER  Santa Monica Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1338 20th Street Santa Monica, CA 90404	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interviews and record review the facility failed to supervise and monitor the whereabouts of one of four residents (Resident 1). On 9/05/2025 the facility admitted Resident 1 from a general acute care hospital (GACH) with diagnoses including hearing voices to kill himself and verbalized to Registered Nurse (RN) 1 and Licensed Vocational Nurse (LVN) 1 that he wanted to leave the facility. This deficient practice resulted in Resident 1 eloping (the unauthorized departure of a patient from a healthcare facility without notifying staff or receiving proper discharge) from the facility on 9/06/2025 after 8:30 AM without notifying any facility staff. Resident 1's whereabouts remain unknown. Findings: A record review of Resident 1's GACH Physician Psychiatric Evaluation Note dated 8/30/2025, indicated, Resident 1 had a history of bipolar disorder with psychotic features (a collection of symptoms, like hallucinations [sensory experiences without real stimuli] and delusions (false beliefs), that signify a loss of contact with reality). The Physician Psychiatric Evaluation Note also indicated Resident 1 has been hearing voices, telling him to kill himself. A record review of Resident 1's admission record (face sheet - a document containing demographic and diagnostic information) indicated the facility admitted Resident 1 on 9/05/2025 with diagnoses including cellulitis (a deep infection of the skin caused by bacteria) of the buttock, bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs) with current episode depressed, severe, with psychotic features, anxiety disorder (a condition of excessive worry about daily issues and situations), schizoaffective disorder, bipolar type (a rare type of mental illness that has symptoms of both schizophrenia [a mental illness characterized by disturbances in thought] and symptoms of bipolar [extreme highs-mania and severe lows-depression]) and other specific personality disorders. A record review of Resident 1's facility History and Physical (H&amp;P - a physician's complete patient examination) dated 9/05/2025, indicated Resident 1 had the diagnoses of gluteal (buttocks) cellulitis, and bipolar disorder. The H&amp;P also indicated Resident 1 had the mental capacity to understand and make medical decisions. A record review of Resident 1's GACH Discharge Nursing Note dated 9/05/2025, indicated Resident 1's list of problems included aggressive behavior and schizoaffective disorder. A record review of Resident 1's 72 Hour Monitoring document dated 9/05/2025 at 00:34 AM, indicated that the primary focus for Resident 1 is behavioral. The 72-hour monitoring document under evaluation and interventions also indicated, Effective: Continue current interventions and monitoring. A record review of Resident 1's Release Form Responsibility for Discharge Against Medical Advice (AMA - a patient choosing to leave a hospital, clinic, or other healthcare facility before the medical team has recommended or completed treatment, or in direct opposition to their team's advice to stay) form, indicated Resident 1 signed AMA. However, the AMA form was missing a date and the signature of staff who witnessed Resident 1 sign AMA. A record review of Resident 1's Nursing Progress Notes dated 9/06/2025 at 11:58 AM, indicated Resident 1 left the facility AMA. A record review of Resident 1's Physician Order Summary Report dated 9/06/2025 did not indicate Resident 1 was discharged AMA. A record review of Resident 1's Elopement Risk Evaluation dated 9/05/2025, indicated Resident 1 was at risk for elopement. A record review of Resident 1's Baseline Care Plan (CP) dated 9/05/2025, indicated Resident 1's level of consciousness (refers to a person's state of alertness and awareness of their surroundings, ranging from full wakefulness to complete unconsciousness) at the time of assessment was alert. The CP also indicated Resident 1 can independently perform activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and did not need to use any mobility devices (helps a person walk or move from place to place when one has a disability or injury) to walk. A record review of the facility's Resident Elopement list dated 9/13/2025, indicated, Resident 1 left without notifying anyone, on 9/06/2025 at 9 AM. A record review of Resident 1's Nurse's Note dated 9/06/2025 at 10 AM, indicated RN 5 indicated, MD (medical doctor) made aware regarding [Resident 1] leaving the facility without notifying any facility staff. A record review of Resident 1's Change of Condition (COC - a significant change in a resident's health or functional status) dated 9/06/2025 indicated, MD was notified on 9/06/2025 at around 9:30 AM that Resident 1 left the facility without notifying any staff. During an interview on 9/13/2025 at 11:47 AM with the Director of Nursing (DON), the DON stated Resident 1 left the facility on 9/06/2025 and the resident's whereabouts were unknown. During an observation on 9/13/2025 at 3 PM, ambulatory residents were observed walking down the hallway, however, no staff were observed checking on the residents' whereabouts, and no staff observed at Nurses Stations 1 and 2. During an observation on 9/13/2025 at 3 PM the facility had two elevators. The common elevator was located across</p>		